Calendar No. 258

100TH CONGRESS
1ST SESSION

H. R. 2470

IN THE SENATE OF THE UNITED STATES

JULY 24 (legislative day, JUNE 23), 1987
Received; read twice and ordered to be placed on the calendar

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AN ACT

To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Catastrophic Protection Act of 1987".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to

or repeal of, a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Sec. 101. Inpatient hospital services.
Sec. 102. Extended care services.
Sec. 103. Hospice care.
Sec. 104. Blood deductible.
Sec. 105. Home health benefits.
Sec. 106. Imposition of supplemental medicare premium.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Sec. 201. Limitation on medicare out-of-pocket expenses under part B.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. In-home care for certain chronically dependent individuals.
Sec. 204. Extending home health services.
Sec. 205. Increase in maximum payment allowed for outpatient mental health services.
Sec. 206. Adjustments in medicare part B premium.
Sec. 207. Treatment of prepaid health plans.
Sec. 208. Mailing of notice of medicare benefits and participating physician directories.
Sec. 209. Changes in certification of medicare supplemental health insurance policies.
Sec. 210. Extension of social HMO demonstration project.
Sec. 211. Research on long-term care for medicare beneficiaries.
Sec. 212. Study of adult day care services.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301. Requiring medicaid buy-in of premiums and cost-sharing for indigent medicare beneficiaries.
Sec. 302. Protection of income and resources of couple for maintenance of community spouse.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Sec. 401. Establishment.
Sec. 402. Duties.
Sec. 403. Membership.
Sec. 404. Staff and consultants.

Sec. 405. Powers.
Sec. 406. Report.
Sec. 407. Termination.
Sec. 408. Authorization of appropriations.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

SEC. 101. INPATIENT HOSPITAL SERVICES.

(a) APPLICATION OF INPATIENT HOSPITAL DEDUCTIBLE ON A CALENDAR YEAR BASIS AND LIMITATION TO ONE DEDUCTIBLE EACH YEAR.—The first sentence of section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) is amended—

(1) by striking "any spell of illness" and inserting "the first period of continuous hospitalization (as defined in subsection (b)(3)) that begins in a calendar year", and

(2) by inserting "for that calendar year" after "inpatient hospital deductible".

(b) ELIMINATION OF GENERAL DAY LIMITATION ON INPATIENT HOSPITAL SERVICES.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) by amending paragraph (1) of subsection (a) to read as follows:

"(1) inpatient hospital services;";

(2) in subsection (b)—

(A) in the matter before paragraph (1), by striking "during a spell of illness may not (subject to subsection (c))" and inserting "may not",

(B) by striking paragraph (1), and

(C) by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively; and

(3) by amending subsection (c) to read as follows:

"(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

"(2) The period described in this paragraph—

"(A) begins on the first day of medicare entitlement, and

"(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

"(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

"(4) In this subsection:

"(A) The term 'first day of medicare entitlement' means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

"(B) The term 'inpatient mental health services' means—

"(i) inpatient psychiatric hospital services, and

"(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.".

(c) ELIMINATION OF COINSURANCE AMOUNTS FOR INPATIENT HOSPITAL SERVICES.—(1) Section 1813(a)(1) (42 U.S.C. 1395e(a)(1)) is amended by striking the second sentence.

(2) Section 1814(d)(3) (42 U.S.C. 1395f(d)(3)) is amended—

(A) by striking "60 percent" and "80 percent" and inserting "100 percent" both places, and

(B) by striking "two-thirds of".

(d) DETERMINATION OF PART A PREMIUM.—Subsection (d) of section 1818 (42 U.S.C. 1395i(2)) is amended to read as follows:

"(d)(1) The Secretary shall, during September of each year (beginning with 1987), estimate the monthly actuarial

rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).".

(e) CONFORMING AMENDMENTS.—

(1) DROPPING "SPELL-OF-ILLNESS" CONCEPT.—Section 1861 (42 U.S.C. 1395x) is amended—

(A) by striking subsection (a);

(B) in subsection (e)—

(i) by striking the second sentence, and

(ii) in the fifth sentence, by striking ", except for purposes of subsection (a)(2),";

(C) in subsection (j)—

(i) in the first sentence, by striking "(other than for purposes of subsection (a)(2))", and

(ii) by striking the second sentence; and

(D) in subsection (y)—

(i) in paragraph (1), by striking "(except for purposes of subsection (a)(2))", and

(ii) in paragraphs (2) and (3), by striking "spell of illness" and "spell" each place either appears and inserting "year".

(2) MISCELLANEOUS.—(A) Section 1812 (42 U.S.C. 1395e) is amended by striking subsection (g).

(B) Section 1832(b) (42 U.S.C. 1395k(b)) is amended by striking " 'spell of illness'," and the comma before "and".

(f) EFFECTIVE DATE AND TRANSITION.—

(1) DEDUCTIBLE.—(A) The amendments made by subsection (a) shall apply to the deductible for 1988 and succeeding years.

(B) HOLD HARMLESS AGAINST TRANSITION FOR CALENDAR YEAR DEDUCTIBLE.—In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act, as in effect on December 31, 1987) began before January 1, 1988, and had not yet ended as of such date, the amendment made by subsection (a) shall not apply to services furnished during that spell of illness during 1988 or 1989.

(2) EXTENSION OF BENEFITS AND COINSURANCE.—The amendments made by subsections (b) and (c) shall apply to inpatient hospital services furnished on or after January 1, 1988.

(3) PREMIUM.—The amendments made by subsection (d) shall apply to premiums for months beginning with January 1988.

(4) MISCELLANEOUS.—The amendments made by subsection (e) shall take effect on January 1, 1988.

(5) ADJUSTMENT IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—In adjusting—

(A) DRG prospective payment rates under section 1886(d) of the Social Security Act,

(B) target amounts under section 1886(b)(3) of such Act,

(C) outlier cutoff points under section 1886(d)(5)(A) of such Act, and

(D) weighting factors under section 1886(d)(4) of such Act,

the Secretary shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the amendments made by subsection (b) of this section (eliminating a day limitation on inpatient hospital services).

SEC. 102. EXTENDED CARE SERVICES.

(a) COINSURANCE RATE OF 20 PERCENT OF NATIONAL AVERAGE PER DIEM COST FOR SERVICES FURNISHED DURING FIRST 7 DAYS OF EACH CALENDAR YEAR.—Paragraph (3) of section 1813(a) (42 U.S.C. 1395e(a)) is amended to read as follows:

"(3)(A) The amount payable for post-hospital extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 8th day) on which he is furnished such services during the year.

"(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per

diem reasonable cost recognized under this title for post-hospital extended care services which will be furnished in the succeeding calendar year.

"(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount which shall apply to post-hospital extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).".

(b) EXTENDING TO 150 DAYS IN EACH CALENDAR YEAR.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(2)(A), by striking "100 days during any spell of illness" and inserting "150 days during any calendar year", and

(2) in subsection (b)(1), as redesignated by section 101(b)(2)(C), by striking "during such spell after such services have been furnished to him for 100 days during such spell" and inserting "during a calendar year after such services have been furnished to the individual for 150 days during that year".

(c) ELIMINATING HOSPITAL REQUIREMENT FOR COVERAGE OF EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(A) in subsection (a)(2)—

(i) by striking "(2)(A)" and inserting "(2)",

(ii) by striking "post-hospital", and

(iii) by striking ", and (B)" and all that follows up to the semicolon; and

(B) by striking subsection (f).

(2) CONFORMING AMENDMENTS.—

(A) Title XVIII is amended by striking "post-hospital" each place it appears in each of the following provisions:

(i) Subsections (b)(1) (as redesignated by section 101(b)(2)(C) of this Act) and (e) of section 1812 (42 U.S.C. 1395d).

(ii) Subsection (a)(3) of section 1813 (42 U.S.C. 1395e).

(iii) Paragraphs (2)(B) and (6) of section 1814(a) (42 U.S.C. 1395f(a)).

(iv) Subsections (v)(1)(G), (v)(2), (v)(3), and (y) of section 1861 (42 U.S.C. 1395x).

(v) Subsections (b)(3) and (d) of section 1866 (42 U.S.C. 1395cc).

(vi) Subsections (d) and (f) of section 1883 (42 U.S.C. 1395tt).

(B) Section 1811 (42 U.S.C. 1395c) is amended by striking "hospital, related post-hospital" and inserting "inpatient hospital services, extended care services".

(C) Section 1814(a)(2)(B) (42 U.S.C. 1395f(a)(2)(B)) is amended by striking ", for any of the conditions" and all that follows up to the semicolon.

(D) Section 1861 (42 U.S.C. 1395x) is amended—

(i) in subsection (e), as amended by section 101(e)(1)(B) of this Act—

(I) in the matter before paragraph (1), by striking "paragraph (7) of this subsection, and subsection (i) of this section" and inserting "and paragraph (7) of this subsection", and

(II) in the second sentence, by striking "section 1814(f)(2), and subsection (i) of this section" and inserting "and section 1814(f)(2)";

(ii) by striking subsection (i), and

(iii) by striking paragraph (4) of subsection (y).

(d) CONFORMING AMENDMENT.—Section 1861(y)(3) (42 U.S.C. 1395x(y)(3)) is amended by striking "equal to" and all that follows through "31st day" and inserting "equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 8th day".

(e) EFFECTIVE DATES.—

(1) The amendments made by subsections (a), (b), and (d) shall apply to extended care services furnished on or after January 1, 1988.

(2) The amendments made by subsection (c) shall apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.

SEC. 103. HOSPICE CARE.

(a) EXTENSION OF COVERAGE PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(4), by striking "and one subsequent period of 30 days" and inserting ", a subsequent period of 30 days, and a subsequent extension period";

(2) in subsection (d)(1), by striking "and one subsequent period of 30 days" and inserting ", a subse-

quent period of 30 days, and a subsequent extension period''; and

(3) in subsection (d)(2)(B), by inserting ''or a subsequent extension period'' after ''30-day period''.

(b) CONTINUED CERTIFICATION OF TERMINAL ILLNESS FOR EXTENDED BENEFITS.—Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(1) by striking ''and'' at the end of clause (i),

(2) by striking the semicolon at the end of clause (ii) and inserting '', and'', and

(3) by adding at the end the following new clause:

''(iii) in a subsequent extension period, the medical director or physician described in clause (i)(III) recertifies at the beginning of the period that the individual is terminally ill;''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care furnished on or after January 1, 1988.

SEC. 104. BLOOD DEDUCTIBLE.

(a) IN GENERAL.—Paragraph (2) of section 1813(a) (42 U.S.C. 1395e(a)) is amended to read as follows:

''(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quanti-

ties of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

"(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.".

(b) EFFECTIVE DATE.—(1) The amendment made by subsection (a) shall apply to blood or blood cells furnished on or after January 1, 1988.

(2) In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act) began before January 1, 1988, and had not yet ended as of

such date, the amount of any deductible under section 1813(a)(2) of such Act (as amended by subsection (a)) shall be reduced during that spell of illness during 1988 or 1989 to the extent the deductible under section 1813(a)(2) of such Act (as in effect before January 1, 1988) was applied during the spell of illness.

SEC. 105. HOME HEALTH BENEFITS.

(a) COVERAGE UNDER PART A ONLY IF NO COVERAGE UNDER PART B.—Section 1812 (42 U.S.C. 1395d), as amended by sections 101(e)(2) and 102(c)(1)(B) of this Act, is amended—

(1) in subsection (a)(3), by inserting "subject to subsection (f)," after "(3)", and

(2) by striking subsection (g) and by inserting after subsection (e) the following new subsection:

"(f) Subsection (a)(3) shall only apply to home health services provided to an individual during a month in which the individual is not entitled to benefits under part B.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to home health services furnished on or after January 1, 1989.

SEC. 106. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of

tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

"Sec. 59B. Imposition of supplemental medicare premium.

"SEC. 59B. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

"(a) IMPOSITION OF PREMIUM.—In the case of a medicare-eligible individual, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a premium equal to the annual premium for such year determined under subsection (b).

"(b) DETERMINATION OF AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection—

"If the adjusted gross income for the taxable year is:		The annual premium for the taxable year is:
Over:	But not over:	
$ 0	$ 6,000	$ 0
6,000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170

"If the adjusted gross income for the taxable year is: Over:	But not over:	The annual premium for the taxable year is:
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580.

"(2) SPECIAL RULE WHERE INDIVIDUAL NOT ELIGIBLE FOR ENTIRE TAXABLE YEAR; SHORT TAXABLE YEARS.—If an individual is not a medicare-eligible individual for each month during his taxable year,

the annual premium determined under this subsection shall be an amount which bears the same ratio to the amount determined under paragraph (1) as—

"(A) the number of months during the taxable year for which such individual is a medicare-eligible individual, bears to

"(B) 12.

A similar rule shall apply in the case of a taxable year of less than 12 months; except that adjusted gross income for the taxable year shall be annualized.

"(3) SPECIAL RULE FOR JOINT RETURNS.—In the case of a joint return—

"(A) this section shall be applied separately with respect to each spouse, and

"(B) the adjusted gross income of each spouse shall be ½ of their combined adjusted gross income.

"(4) ADJUSTMENTS TO TABLE.—

"(A) IN GENERAL.—Not later than December 15 of 1988 and each subsequent calendar year, the Secretary shall prescribe a table which shall apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in the succeeding calendar year.

"(B) METHOD OF PRESCRIBING TABLE.—The table which, under subparagraph (A), is to apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in any calendar year shall be prescribed—

"(i) by increasing each dollar amount setting forth the amount of the premium in such table by the sum of the medicare inflation factor and the prescription drug factor for such calendar year, and

"(ii) by increasing each other dollar amount in such table by the cost-of-living adjustment for such calendar year (as defined in section 1(f)(3)).

"(C) MEDICARE INFLATION FACTOR.—For purposes of subparagraph (B), the medicare inflation factor for any calendar year is the percentage (if any) by which—

"(i) the medicare value for such calendar year, exceeds

"(ii) the medicare value for 1988.

"(D) PRESCRIPTION DRUG FACTOR.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the prescription drug factor—

"(I) for 1988 is 0 percent;

"(II) for 1989 is 5.5 percent; and

"(III) for a subsequent year is the percent determined under clause (ii) for that year.

"(ii) DETERMINATIONS.—In September of each year (beginning with 1989) the Secretary shall establish a prescription drug factor for purposes of subparagraph (B) for taxable years beginning in the succeeding calendar year. Subject to clauses (iv) and (v), the prescription drug factor with respect to taxable years beginning in the succeeding calendar year shall be the percent the Secretary estimates to be necessary so that the total amount of premiums which the Secretary estimates is collectible under this section for taxable years beginning in that succeeding calendar year by virtue of the establishment of such factor is equal to ⅓ of the amount estimated by the Secretary of Health and Human Services under section 1839(g)(2)(C) of the Social Security Act with respect to premiums in that succeeding calendar year.

"(iii) DETERMINATION OF SURPLUS OR DEFICIT.—In September of each year (beginning with 1991) the Secretary shall determine—

"(I) the total amount of additional premiums which are estimated to be collectible under this section with respect to taxable years beginning in calendar years after 1988 and before the previous calendar year by virtue of the prescription drug factor for those years, and

"(II) whether the amount described in subclause (I) is greater or less than 25 percent of the sum of the totals determined by the Secretary of Health and Human Services under section 1839(g)(1)(C)(i)(II) of the Social Security Act which were paid for calendar years after 1988 and before the previous calendar year.

"(iv) ADJUSTMENT.—If the Secretary determines under subclause (II) of clause (iii) in a year that there is a surplus or deficit described in that subclause, the Secretary shall

adjust the prescription drug factor otherwise determined under this subparagraph for taxable years beginning in the succeeding year so as to reduce or increase, respectively, the aggregate amount of the additional premiums which are estimated to be collectible under this section for taxable years beginning in that succeeding year by the amount of such surplus or deficit. In making such adjustment, the Secretary shall take into account the effect of previous adjustments made under this clause.

"(v) LIMIT ON INCREASE.—Notwithstanding the previous provisions of this subparagraph, in no case shall the prescription drug factor for a year (after 1990) exceed 120 percent of such factor for the previous year.

"(E) ROUNDING.—If any increase determined under subparagraph (B) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

"(c) DEFINITIONS AND SPECIAL RULES.—

"(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'medicare-eligible individual' means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

"(B) EXCEPTIONS.—The term 'medicare-eligible individual' shall not include for any month—

"(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act,

"(ii) any individual who is required to pay a premium for such month increased or computed under paragraph (4) or (5) of section 1839(e) of the Social Security Act, or

"(iii) any qualified nonresident.

"(C) TREATMENT OF INDIVIDUALS WHO HAVE ATTAINED AGE 65.—An individual (other than a nonresident alien) who has attained age 65 shall be treated as a medicare-eligible individual for the month in which he attains age 65 and any

subsequent month unless such individual establishes to the satisfaction of the Secretary that he is not a medicare-eligible individual for the month concerned.

"(2) MEDICARE VALUE.—

"(A) IN GENERAL.—For purposes of this section, the term 'medicare value' means, for any calendar year, the sum of the Medicare part A value for January of such calendar year and the Medicare part B value for January of such calendar year.

"(B) MEDICARE PART A VALUE.—For purposes of subparagraph (A), the term 'Medicare part A value' means, with respect to any month, an amount equal to 50 percent of the monthly actuarial rate promulgated under section 1818(d)(1) of the Social Security Act for such month.

"(C) MEDICARE PART B VALUE.—For purposes of subparagraph (A), the term 'Medicare part B value' means, with respect to any month, an amount equal to the excess of—

"(i) the amount equal to twice the monthly actuarial rate established under section 1839(a)(1) of the Social Security Act for

the calendar year which includes such month, over

"(ii) the amount of the monthly premium for such month established under section 1839 of such Act (without regard to subsections (b), (e)(4), (e)(5), and (f) through (h) thereof).

"(3) QUALIFIED NONRESIDENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'qualified nonresident' means, with respect to any month during the taxable year, any individual if—

"(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is or will be made under part A of title XVIII of the Social Security Act,

"(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

"(iii) such individual is present in a foreign country or countries for at least 330 full days during—

"(I) the 12-month period ending at the close of the taxable year, and

"(II) each of the 4 consecutive preceding 12-month periods.

"(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

"(4) COORDINATION WITH OTHER PROVISIONS.—

"(A) NOT TREATED AS MEDICAL EXPENSE.—The premium imposed by this section shall not be treated as an expense paid for medical care for purposes of section 213.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax imposed by section 55.

"(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the premium imposed by this section shall be treated as if it were a tax imposed by section 1.

"(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the premium imposed by this section."

(b) REPORTING REQUIREMENT.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end thereof the following new section:

"SEC. 6050O. RETURNS RELATING TO INDIVIDUALS ENTITLED TO RECEIVE BENEFITS UNDER MEDICARE PART A.

"The Secretary of Health and Human Services shall make a return (at such times and in such form as the Secretary may prescribe) setting forth the name, address, and TIN of each individual who is entitled to receive benefits (other than by reason of the payment of a premium referred to in clause (i) or (ii) of section 59B(c)(1)(B)) under part A of title XVIII of the Social Security Act for any month during the

calendar year and the number of months in the calendar year for which the individual is so entitled."

(c) CLERICAL AMENDMENTS.—

(1) The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"PART VIII. SUPPLEMENTAL MEDICARE PREMIUM."

(2) The table of sections for subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end thereof the following new item:

"Sec. 60500. Returns relating to individuals entitled to receive benefits under Medicare part A."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1987.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND MEDICARE SUPPLEMENTAL HEALTH INSURANCE

SEC. 201. LIMITATION ON MEDICARE OUT-OF-POCKET EXPENSES UNDER PART B.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) by inserting after subsection (e) the following new subsection:

"(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

"(2) In this subsection, the term 'out-of-pocket part B expenses' means—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a),

in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

"(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

"(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

"(A) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a con-

tract or with respect to individuals furnished services through the organization or a facility if payments were to be made on an individual-by-individual basis, and

"(B) the organization shall provide assurances satisfactory to the Secretary that the organization and such a facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility, or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year."; and

(2) in subsections (c) and (g), by striking "(a) and (b)" each place it appears and inserting "(a), (b), and (f)".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits).".

(c) NOTICE FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) will provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) sufficient out-of-pocket part B expenses in a calendar year to qualify for payment for additional incurred expenses to be made pursuant to section 1833(f), with a notice, in a form appropriate for presentation to a physician, that—

"(i) states that the individual has reached the part B catastrophic limit on out-of-pocket expenses for the year, and

"(ii) encourages such a physician not to charge the individual amounts in excess of the reasonable charge recognized under this section and to accept payment on an assignment-related basis for physicians' services furnished the individual during the remainder of the year;".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J)(i) drugs described in subsection (t)(2)(A) used in immunosuppressive therapy furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant, and (ii) covered outpatient drugs (as defined in subsection (t)(2)); and", and

(2) in subsection (t)—

(A) by striking "subsection (m)(5)" and inserting "subsections (m)(5) and (s)(2)(J)(ii) and paragraph (2)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) The term 'covered outpatient drug' means—

"(A) a drug which—

"(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

"(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

"(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2), and does not include drugs under the conditions described in subsection (s)(2)(J)(i).".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395l(b)) is amended—

(A) in subsection (a)(1)—

(i) by striking "and" before "(H)", and

(ii) by adding at the end the following: "(I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2), and (J) with respect to drugs under the conditions described in section 1861(s)(2)(J)(i), the amounts paid shall be the amounts determined under subsection (m)(2)

(without regard to the deductible established under subsection (m)(1)(A) but taking into account the deductible established under subsection (b))";

(B) in subsection (b)—

(i) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(ii) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(C) by adding at the end the following new subsection:

"(m) PAYMENT FOR COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) IN GENERAL.—Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred (or has had paid on the individual's behalf) expenses for covered outpatient drugs dispensed in the year (during a period in which the individual is entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

"(B) RESPONSE TO APPLICATION.—If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to whether or not the individual has met such requirement.

"(C) DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), the amount specified in this subparagraph for—

"(I) 1989 is $500;

"(II) 1990 and 1991 is the amount specified under this subparagraph for the previous year increased by the percentage change in the medical care component of the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) for the 12-month period ending in August in that previous year; and

"(III) any succeeding year is the amount specified under this subpara-

graph for the previous year increased by the percentage increase determined under the index under clause (ii) in September of the previous year.

"(ii) COVERED OUTPATIENT DRUG INDEX.—The Secretary shall establish by regulation an index which reflects the prices of covered outpatient drugs. The Secretary shall use, as a base point, the prices for the drugs as of August 1990. In September of each year (beginning with 1991) the Secretary shall determine the percentage change in the index during the 12-month period ending with the previous month.

"(iii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the next highest multiple of $1.

"(iv) PUBLICATION.—In September of each year (beginning with 1989) the Secretary shall publish the deductible established under this subparagraph for the following year.

"(D) ADJUSTMENT TO PREVENT EXCESSIVE PREMIUM INCREASES.—If the monthly actuarial

rate determined under section 1839(g)(1) for months in a year (after 1990) exceeds 120 percent of the basic monthly premium increase described in section 1839(g)(2) for the previous year, the Secretary shall increase the amount otherwise specified under subparagraph (C) for that year (and only for that year) by such an amount as will assure that—

"(i) the aggregate amount of the monthly premium increase which is estimated to be collected or paid under section 1839(g)(3) for the year for all enrollees,

is equal to—

"(ii) 75 percent of the amount determined under section 1839(g)(1)(B)(i) for such year.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the deductible established under paragraph (1)(A) (or, with respect to drugs described in section 1861(s)(2)(J)(i), the deductible established under subsection (b)) and except as provided in subparagraph (C), the amounts payable under this part with respect to a covered outpatient drug or a

drug described in section 1861(s)(2)(J)(i) is equal to—

"(i) the lesser of—

"(I) the actual charge for the drug, or

"(II) the applicable payment limit described in paragraph (3) or paragraph (4); minus

"(i) 20 percent of the actual charge for the drug.

"(B) PUBLICATION OF PAYMENT LIMITS.—The Secretary, before each payment calculation period (as defined in paragraph (9)(C)) beginning on or after January 1, 1989, shall provide for the distribution to participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under paragraphs (3) and (4).

"(C) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

"(i) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished covered outpatient drugs through the organization or a facility if payments were to be made on an individual-by-individual basis, and

"(ii) the organization shall provide assurances satisfactory to the Secretary that the organization or such a facility will not undertake to charge an individual more than 20 percent of such reasonable cost plus any amounts payable by the individual as a result of paragraph (1).

"(3) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—

"(A) IN GENERAL.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source

drug and has a restrictive prescription (as defined in paragraph (9)(B)), the payment limit for the drug under this subsection is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tablet or unit wholesale price for the drug (as determined under subparagraph (B)), and

"(ii) an administrative allowance in the amount determined under paragraph (5).

"(B) DETERMINATION OF UNIT PRICE.—For purposes of this paragraph, the Secretary shall determine, with respect to dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1989), the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on wholesale prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under subparagraph (A), on a national basis; except that the Secretary may make

such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale prices for a drug product.

"(4) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—

"(A) IN GENERAL.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (B)(i), and

"(ii) an administrative allowance in the amount determined under paragraph (5).

"(B) UNIT LIMIT.—

"(i) IN GENERAL.—The amount specified under this clause with respect to a multiple source drug dispensed in a payment calculation period is 50 percent of the brand name reference price (established under clause (ii)) for the reference drug product (as defined in clause (iv)) for the period.

"(ii) BRAND NAME REFERENCE PRICE.—The Secretary shall establish, for purposes of clause (i), a brand name reference price for each reference drug product for each payment calculation period. The brand name reference price with respect to a reference drug product—

"(I) for the 6-month period beginning with January 1987, is the average per tablet or unit wholesale price (based on purchases in reasonable quantities) for the reference drug product as of January 1, 1987, or

"(II) for a subsequent payment calculation period, is the brand name reference price established for the previous period increased by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city average, as published by the Bureau of Labor Statistics) for the 6-month period ending in the third month of the previous period.

In the case of a reference drug product which is not available as of January 1, 1987,

but which is first available in a payment calculation period after such date, the Secretary shall establish the brand name reference price as the average per tablet or unit wholesale price for the reference drug product (based on purchases in reasonable quantities) in the first month of the first payment calculation period in which it is available.

"(iii) BASIS.—The Secretary shall establish brand name reference prices under clause (ii) on a national basis; except that the Secretary may establish such prices on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale for a drug product.

"(iv) REFERENCE DRUG PRODUCT DEFINED.—In this subparagraph, the term 'reference drug product' means, with respect to a multiple source drug, the drug product described in paragraph (9)(A) in reference to which other drug products are rated as therapeutically equivalent in the publication described in such paragraph.

"(5) COMPUTATION OF ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) FOR 1989.—For drugs dispensed in a payment calculation period beginning in 1989, the administrative allowance under this paragraph is $4.50.

"(B) FOR LATER YEARS.—For drugs dispensed in a subsequent payment calculation period, the administrative allowance under this paragraph is the administrative allowance under this paragraph for the preceding calculation period increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce in its 'Survey of Current Business') over the 2-quarter period ending with the second quarter preceding the payment calculation period. Any allowance determined under the preceding sentence which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(6) ASSURING APPROPRIATE UTILIZATION.—

"(A) DENIAL OF PAYMENT FOR ABUSIVE PRACTICES.—In order to prevent abusive practices in the prescribing or dispensing of covered outpatient drugs, the Secretary may provide that

payment for covered outpatient drugs may not be made if they are prescribed or dispensed with excessive frequency or in excessive quantities.

"(B) UTILIZATION REVIEW.—The Secretary shall establish a utilization review program for covered outpatient drugs to identify instances of unnecessary or inappropriate prescribing or dispensing practices and to identify quality of care problems.

"(7) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—In the case of covered outpatient drugs furnished by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members—

"(A) for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members and other individuals not entitled to benefits with respect to such drugs, and

"(B) for purposes of meeting the deductible established under paragraph (1), there shall be taken into account the standard charges that are fully or partially prepaid for covered outpatient drugs.

"(8) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, not later than March 1 of each year (beginning with 1989), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866, and

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(i) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations', available on the first day of the third month before the beginning of the period), and

"(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand

medically necessary') recognized by the Secretary, that the particular drug must be dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.".

(2) REPORT ON PAYMENT LIMITS.—The Secretary of Health and Human Services shall review the payment limits described in paragraphs (3) and (4) of section 1833(m) of the Social Security Act on covered outpatient drugs and shall report to Congress, by not later than April 1, 1989, on the appropriateness of such limits. The Secretary shall include in such report such recommendations for changes in such limits as may be appropriate.

(3) REPORT ON COVERED OUTPATIENT DRUG INDEX.—Before January 1, 1991, the Secretary of Health and Human Services shall report to the Congress on the covered outpatient drug index established under section 1833(m)(1)(C)(ii) of the Social Security Act (as added by the amendment made by paragraph (1)(C)).

(c) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended—

(1) in subclauses (III) and (IV) of subsection (c)(2)(B)(ii), by inserting "or by participating pharmacies" after "participating physicians" each place it appears;

(2) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: "and, with respect to a supplier of covered outpatient drugs, is a participating pharmacy (as defined in subsection (i)(1))"; and

(3) by adding after subsection (h) the following new subsection:

"(i)(1) For purposes of this section, the term 'participating pharmacy' means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as 'medicare beneficiaries'), and

"(ii) not to charge medicare beneficiaries more for such drugs than the amount it charges to the general public.

"(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

"(C) The entity agrees—

"(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

"(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

"(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) Effective January 1, 1992, the entity agrees to submit all requests for payment under this part to carriers electronically; except that the Secretary may waive the requirement of this subparagraph (in accordance with regulations) in cases where its imposition would pose an undue hardship on an entity.

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3), (4), and (5) of section 1833(m).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

"(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(d) LIMITATION TO 60-DAY PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

(6) by adding at the end the following new paragraph:

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a 60-day supply.".

(e) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—For amendments providing for additional premiums to pay for the additional benefits provided under the amendments made by this section, see sections 106(a) and 206(d) of this Act.

(f) USE OF CARRIERS IN ADMINISTRATION.—

(1) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c) of this Act, is amended—

(A) by striking "and" at the end of subparagraph (H),

(B) by adding "and" at the end of subparagraph (I), and

(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) offer to receive requests for payments for such drugs through electronic communciations, and

"(ii) respond to requests by participating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;".

(2) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to carrying out functions relating to payment for the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.".

(g) MODIFICATION OF HMO/CMP RISK-SHARING CONTRACTS TO COUNT EXPENSES OF MEMBERS BEFORE ENROLLMENT.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

"(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.".

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1833(m)," after "1833(b),"

and

(B) by inserting "and in the case of covered outpatient drugs, 20 percent of the actual charges for the drugs" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

(3) Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) in paragraph (3)(C) (as subsequently amended by section 301(d)(2) of this Act), by inserting "and, subject to paragraph (4), the annual deductible under section 1833(m)(1)" after "1833(b)"; and

(B) by adding at the end the following new paragraph:

"(4) Instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1833(m)(1), a State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a)(10)(A)(i).".

(i) BENEFICIARY DRUG COST SURVEY AND CBO REPORT.—

(1) SURVEY.—(A) The Secretary of Health and Human Services shall conduct a statistically valid survey of expenses for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act) incurred by medicare beneficiaries.

(B) In developing the design of the survey, the Secretary shall consult with the Comptroller General and the Director of the Congressional Budget Office.

(C) The survey shall be designed so as to provide information on the distribution of expenses for covered outpatient drugs for medicare beneficiaries generally and, within the population of such beneficiaries, the distribution of such expenses by age, sex, income, and institutionalized status.

(D) The Secretary shall report to Congress, by not later than March 1, 1989, a report on the survey conducted under this paragraph.

(2) REESTIMATION OF COSTS.—The Director of the Congressional Budget Office shall transmit to the Congress, not later than 2 months after the date the report is made under paragraph (1), the Director's estimate of the expenditures which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the

medicare program for covered outpatient drugs (under the amendments made by this section).

(j) PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1846. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than October 1, 1988, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug re-

imbursement, as well as at least one individual who is a medicare beneficiary.

"(b) The Commission shall make recommendations to the Congress not later than March 1 of each year concerning methods for payment for covered outpatient drugs under this part.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(k) ADDITIONAL STUDIES.—The Secretary of Health and Human Services shall conduct studies on the following issues:

(1) The extent of private or other third-party insurance coverage of covered outpatient drugs among medicare beneficiaries.

(2) A comparison of published average wholesale prices and actual pharmacy acquisition costs by type of pharmacy.

(3) The overhead costs of retail pharmacies.

(4) Potential application of new claims processing and billing technologies to payment for covered outpatient drugs.

(5) Methods for review of utilization of covered outpatient drugs.

(6) Alternative payment methodologies for covered outpatient drugs that promote greater program efficiency, including use of lower cost medications.

(7) The potential for induced demand resulting from the coverage of covered outpatient drugs under the medicare program.

As part of such studies the Secretary shall conduct a longitudinal study on the use of covered outpatient drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage. The Secretary shall report to Congress on the results of such studies over a period ending not later than January 1, 1991.

(l) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to drugs dispensed on or after January 1, 1989.

(2) CARRIERS.—The amendments made by subsections (f) and (j) shall take effect on the date of the enactment of this Act.

(3) HMO/CMP ENROLLMENTS.—The amendment made by subsection (g) shall apply to enrollments effected on or after January 1, 1989.

(4) MEDICAID CHANGES.—(A) The amendments made by subsection (h)(3) apply (except as provided in subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(i) monthly premiums under title XVIII of such Act for months beginning with January 1989, and

(ii) covered outpatient drugs dispensed on or after January 1, 1989.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments

made by subsection (h)(3), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act.

SEC. 203. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by amending subparagraph (A) of paragraph (2) to read as follows:

"(A)(i) home health services, and (ii) subject to section 1839(h)(4), in-home care for a chronically dependent individual for up to 80 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ff)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transfering in and out of a bed or in and out of a chair.".

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876, (i) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such

clause or such a contract or with respect to individuals furnished in-home care through the organization or a facility if payments were to be made on an individual-by-individual basis, and (ii) the organization shall provide assurances satisfactory to the Secretary that the organization or such a facility will not undertake to charge an individual more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b).''.

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting in lieu thereof ''; and''; and

(3) by inserting after subparagraph (E) the following new subparagraph:

''(F) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.''.

(e) ADDITIONAL PREMIUM FOR IN-HOME CARE.—For provision providing for an additional premium to pay for the

additional benefits provided under this section, see section 206(e) of this Act.

(f) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraphs (B), (C), or (D)" and inserting "a succeeding subparagraph of this paragraph",

(ii) by striking "and" at the end of subparagraph (D),

(iii) by adding "and" at the end of subparagraph (E), and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1989, and before January 1, 1992.

(h) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Congress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care.

(i) STUDY OF IN-HOME CARE.—The Secretary shall study, and report to Congress, not later than June 1, 1991, on the extent of use, cost, and effectiveness of in-home care provided to chronically dependent individuals under the amendments made by this section.

SEC. 204. EXTENDING HOME HEALTH SERVICES.

(a) COVERAGE.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sec-

tions 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days, and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1989.

SEC. 205. INCREASE IN MAXIMUM PAYMENT ALLOWED FOR OUTPATIENT MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(c)(1) (42 U.S.C. 13951(c)(1)) is amended by striking "$312.50" and inserting "$1,250".

(b) CONFORMING AMENDMENT.—Section 1833(f), as inserted by section 201 of this Act, is amended by adding at the end the following new paragraph:

"(5) In applying paragraphs (1) and (2), the dollar amount specified in subsection (c)(1) shall be deemed to be $312.50.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for services furnished on or after January 1, 1989.

SEC. 206. ADJUSTMENTS IN MEDICARE PART B PREMIUM.

(a) TRANSITIONAL ADJUSTMENTS IN 1991 AND 1992.—Section 1839(e) (42 U.S.C. 1395r(e)) is amended by adding at the end the following new paragraph:

"(3)(A) Notwithstanding the provisions of subsection (a), but subject to the provisions of subsections (g) and (h), the monthly premium for each individual enrolled under this part for each month—

"(i) in 1991 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

"(ii) in 1992 shall be $1.30 greater than the amount otherwise determined under subsection (a).

The increase in premium amount taking effect under clause (i) shall not be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3), but the increase in premium amount taking effect under clause (ii) shall be taken into account for purposes of determining increases in 1993 and each subsequent year under subsection (a)(3).

"(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).".

(b) PART B PREMIUM FOR RESIDENTS OF U.S. COMMONWEALTHS AND TERRITORIES.—Such section is further amended by adding at the end the following new paragraph:

"(4)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g) and (h), in the case of an individual who is a resident of a commonwealth or territory during a month—

"(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is 1/12th of the product of—

"(i) the amount of the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be paid under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202 and 203 thereof); and

"(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

"(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

"(II) the per capita actuarial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

"(C) The amount described in this subparagraph for a month in—

"(i) 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B) for months in 1989,

increased by the premium increase percentage (as defined in subparagraph (E)(ii)) for 1990; or

"(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage for that succeeding year.

"(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph:

"(i) The term 'commonwealth or territory' means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(ii) The term 'premium increase percentage', for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.".

(c) PART B PREMIUM FOR INDIVIDUALS ENROLLED UNDER PART B BUT NOT ENTITLED TO BENEFITS UNDER PART A.—Such section is further amended by adding at the end the following new paragraph:

"(5)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g) and (h), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

"(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph is 1/12th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be paid under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202 and 203 thereof).

"(C) The amount described in this subparagraph for a month—

"(i) in 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B), increased by the premium increase percentage (as defined in paragraph (4)(E)(ii)) for 1990; or

"(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

"(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the

Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph the term 'part B only individual' means, with respect to a premium for a month, an individual who—

"(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A.".

(d) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—

"(1) DETERMINATION OF ACTUARIAL RATE.—

"(A) FOR 1989.—For purposes of this subsection, the monthly actuarial rate determined according to this paragraph for 1989 is $2.30.

"(B) FOR SUBSEQUENT YEARS.—In September of each year (beginning with 1989) the Secretary shall determine—

"(i) the total of the benefits and administrative costs which he estimates will be paid from the Federal Supplementary Medical Insurance Trust Fund in such succeeding calendar year for covered outpatient drugs and related administrative costs, and

"(ii) a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year, which rate shall, subject to subparagraph (C)(ii), be the rate the Secretary estimates to be necessary so that the aggregate amount of the increase in premiums collected or received under paragraph (3) for such year will equal 75 percent of the total determined under clause (i) for that year.

"(C) ADJUSTMENT FOR PREVIOUS SURPLUSES OR DEFICITS.—

"(i) DETERMINATION AS TO WHETHER TO MAKE AN ADJUSTMENT.—In September of each year (beginning with 1990), the Secretary shall determine—

"(I) the aggregate amount of the monthly premium increases collected or

received under paragraph (3) during the previous year;

"(II) the total of the benefits and administrative costs which the Secretary determines were paid in the previous year from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs; and

"(III) whether the amount described in subclause (I) is greater or less than 75 percent of the total described in subclause (II).

"(ii) ADJUSTMENT TO MONTHLY ACTUARIAL RATE.—If the Secretary determines under clause (i)(III) in a year that there was a surplus or deficit described in that clause in the previous year, the Secretary shall adjust the monthly actuarial rate otherwise determined under subparagraph (B)(ii) for the succeeding year so as to reduce or increase, respectively, the aggregate amount of the monthly premium increases that otherwise would be collected or received under para-

graph (3) during such period by the amount of such surplus or deficit, respectively.

"(2) ESTABLISHMENT OF BASIC MONTHLY DRUG PREMIUM INCREASE.—

"(A) IN GENERAL.—For purposes of paragraph (3), the basic monthly drug premium increase for a year is, subject to subparagraph (B), the monthly actuarial rate determined according to paragraph (1) for months in the year.

"(B) LIMIT ON BASIC MONTHLY DRUG PREMIUM INCREASE.—The basic monthly drug premium increase for months—

"(i) in 1990 may not exceed $3.40, or

"(ii) in 1991 (or a subsequent year) may not exceed 120 percent of the basic monthly drug premium increase under this paragraph for months in the preceding year.

"(C) DETERMINATION OF POTENTIAL PREMIUM REVENUES BASED ON MONTHLY ACTUARIAL RATE.—In September of each year (beginning with 1989) the Secretary shall determine, for purposes of section 59B(b)(4)(D)(ii) of the Internal Revenue Code of 1986, the total of the monthly premium increases which the Secretary estimates would be collected or received in the succeeding

year under paragraph (3) if the monthly actuarial rate (determined under paragraph (1)(A) without regard to any adjustment under paragraph (1)(C)(ii)) were substituted for the basic monthly drug premium increase each place it appears in paragraph (3).

"(3) MONTHLY PREMIUM INCREASE APPLIED.—Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the following:

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the basic monthly drug premium increase described in paragraph (2)(A) for that year.

"(B) RESIDENTS OF COMMONWEALTH AND TERRITORIES.—In the case of an individual who is a resident of a commonwealth or territory (as defined in subsection (e)(4)(E)(i)) during the month, the product of—

"(i) 133⅓ percent of the basic monthly drug premium increase described in paragraph (2)(A) for that year, and

"(ii) the ratio determined by the Secretary for that commonwealth or territory under subsection (e)(4)(B)(ii).

"(C) PART B ONLY INDIVIDUALS.—In the case of a part B only individual (as defined in subsection (e)(5)(E)), 133⅓ percent of the basic monthly drug premium increase described in paragraph (2)(A) for that year.

However, if an increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(4) REPORT ON PROJECTED EXCESS PREMIUM INCREASES.—In May of each year (beginning with 1990), the Secretary shall report to Congress concerning whether, based on the best estimates available at the time for expenditures under this part for covered outpatient drugs, the Secretary anticipates that the monthly actuarial rate determined under paragraph (1) for the succeeding year will exceed the limit on the basic monthly drug premium increase provided in paragraph (2)(B) for that year. If the Secretary determines so, the Secretary shall include in the report recommendations for changes in policies under this part sufficient to reduce expenditures under this part for covered outpatient drugs for that succeeding year so that the

monthly actuarial rate (as reduced by such expenditure reductions) will not exceed the limit on the basic monthly drug premium amount provided in paragraph (2)(B) for the year.''.

(e) ADDITIONAL PREMIUM FOR IN-HOME CARE.—Section 1839 (42 U.S.C. 1395r), as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(h)(1)(A) The Secretary shall, during September of 1988, 1989, and 1990, determine—

''(i) the total of the benefits and administrative costs which he estimates will be paid from the Federal Supplementary Medical Insurance Trust Fund in the succeeding calendar year for in-home care and related administrative costs with respect to such enrollees, and

''(ii) a monthly actuarial rate for in-home care (as defined in section 1861(ff)(1)) which shall be applicable for the succeeding calendar year, which rate shall, subject to subparagraph (B)(ii), be the rate which the Secretary estimates to be necessary so that the aggregate amount of the increase in premiums collected or paid under this subsection for such year will equal 100 percent of the total determined under clause (i) for that year.

"(B)(i) In September of 1990 the Secretary shall determine—

"(I) the aggregate amount of the monthly premium increases collected or received under paragraph (2) during the previous year;

"(II) the total of the benefits and administrative costs which the Secretary determines were paid in the previous year from the Federal Supplementary Medical Insurance Trust Fund for in-home care and related administrative costs; and

"(III) whether the amount described in subclause (I) is greater or less than 100 percent of the total described in subclause (II).

"(ii) If the Secretary determines under clause (i)(III) in a year that there was a surplus or deficit described in that clause in 1989, the Secretary shall adjust the monthly actuarial rate otherwise determined under subparagraph (A)(ii) for 1991 so as to reduce or increase, respectively, the aggregate amount of the monthly premium increases that otherwise would be collected or received under paragraph (2) 1991 by the amount of such surplus or deficit, respectively.

"(2) Subject to paragraph (3), notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December

1988 and before January 1992 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(3) The increase in monthly premium under paragraph (2) for each month—

"(A) in 1989 may not exceed $0.30,

"(B) in 1990 may not exceed $0.50, and

"(C) in 1991 may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in 1990.

"(4) If the monthly actuarial rate determined under paragraph (1) for 1991 exceeds 120 percent of the monthly premium increase provided under paragraph (2) for months in 1990, the Secretary shall decrease the maximum number of hours of in-home care under section 1832(a)(2)(A)(ii) in 1991 by such an amount as will assure that—

"(A) the aggregate amount of the monthly premium increase collected or paid under this subsection for 1991 for all enrollees,

is equal to—

"(B) the total of the benefits and administrative costs which the Secretary estimates will be paid from the Federal Supplementary Medical Insurance Trust

Fund in 1991 for in-home care and related administrative costs for all such enrollees.''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in the second sentence of subsection (a)(1), by inserting ''(other than costs relating to covered outpatient drugs, costs relating to in-home care (as defined in section 1861(ff)(1)), and costs attributable to section 1812(f))'' before the period;

(B) in subsection (a)(2), by striking ''and (e)'' and inserting '', (e), (g), and (h)'';

(C) in subsection (a)(3), by striking ''subsection (e)'' and inserting ''subsections (e), (g), and (h)'';

(D) in the second sentence of subsection (a)(4), by inserting ''(other than costs relating to covered outpatient drugs, costs relating to in-home care (as defined in section 1861(ff)(1)), and costs attributable to section 1812(f))'' before the period; and

(E) in subsection (b), by striking ''determined under subsection (a) or (e)'' and inserting ''otherwise determined under this section (without regard to subsection (f))''.

(2) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) and such premiums shall be computed as though the clause '(other than costs attributable to section 1812(f))' was deleted from paragraphs (1) and (4) of section 1839(a)".

(g) EFFECTIVE DATES.—

(1) TRANSITIONAL ADJUSTMENT.—The amendments made by subsection (a) shall apply to monthly premiums for months beginning with January 1991.

(2) PREMIUMS FOR RESIDENTS OF COMMONWEALTHS AND TERRITORIES.—The amendments made by subsection (b) shall apply to monthly premiums for months beginning with January 1988.

(3) PREMIUMS FOR PART B ONLY INDIVIDUALS, PREMIUM FOR COVERED OUTPATIENT DRUGS, AND CONFORMING AMENDMENTS.—The amendments made by subsections (c), (d), and (f) shall apply to monthly premiums for months beginning with January 1989.

(4) PREMIUM FOR IN-HOME CARE.—The amendments made by subsection (e) shall apply to premiums for months beginning with January 1989 and ending with December 1991.

SEC. 207. TREATMENT OF PREPAID HEALTH PLANS.

(a) ADJUSTMENT OF AAPCC'S AND CONTRACTS FOR RISK-BASED ELIGIBLE ORGANIZATIONS.—The Secretary of Health and Human Services shall—

(1) take into account the amendments made by this Act in estimating the adjusted average per capita cost under section 1876(a) of the Social Security Act for eligible organizations with risk sharing contracts under that section for portions of contract years occurring after December 31, 1987;

(2) modify such contracts, for such portions of contract years, to reflect any adjustments made under paragraph (1); and

(3) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account the amendments made by this Act.

(b) PROVISIONS CONTINUING OF REASONABLE COST REIMBURSEMENT.—For provisions permitting certain prepaid organizations to continue receiving payment on a reasonable cost basis, see—

(1) section 1833(f)(4) of the Social Security Act (as added by section 201(a)(1) of this Act and relating to payment for catastrophic benefits),

(2) section 1833(m)(2)(C) of such Act (as added by section 202(b)(1)(C) of this Act and relating to payment for covered outpatient drugs), and

(3) the last sentence of section 1833(a) of such Act (as added by section 203(c)(3) of this Act and relating to payment for in-home care).

SEC. 208. MAILING OF NOTICE OF MEDICARE BENEFITS AND PARTICIPATING PHYSICIAN DIRECTORIES.

(a) DISTRIBUTION OF NOTICE OF MEDICARE BENEFITS.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. (a) The Secretary shall distribute annually a notice containing—

"(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

"(2) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

"(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance

Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).".

(b) DISTRIBUTION OF PARTICIPATING PHYSICIAN DIRECTORIES.—The second sentence of section 1842(h)(6) (42 U.S.C. 1395u(h)(6)) is amended by inserting after "that area" the following: "and to each individual enrolled under this part and residing in that area".

(c) EFFECTIVE DATES.—

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1988, or, if later, 3 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall first apply to directories for 1988.

SEC. 209. CHANGES IN CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) ESTABLISHMENT OF NEW MEDIGAP STANDARDS.—

(1) RECOMMENDED CHANGES.—The Secretary of Health and Human Services shall report to Congress, not later than 150 days after the date of the enactment of this Act, on changes that should be made in the requirements of subsection (c) of section 1882 of the

Social Security Act for certification of medicare supplemental policies to take into account both the amendments made by this Act, and by any other pertinent Acts enacted by the first session of the 100th Congress, and any recommendations developed by the National Association of Insurance Commissioners.

(2) CONGRESSIONAL ACTION.—It is the sense of Congress that—

(A) Congress will promptly act on such recommendations and provide for appropriate changes in the requirements of subsection (c) of that section, and

(B) States will be expected to adjust their laws in a timely manner to comply with the changes in such requirements.

(b) REQUIRED MAILING OF NOTICE.—

(1) IN GENERAL.—Section 1882(b) (42 U.S.C. 1395ss(b)) is amended by adding at the end the following new paragraph:

"(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1,

1988, is sent a letter by not later than January 31, 1988, that explains—

"(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of February 1, 1988.

(c) REQUIRED SUBMISSION OF ADVERTISING.—

(1) IN GENERAL.—Section 1882(b) is further amended by adding after paragraph (3) the following new paragraph:

"(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisment (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of January 1, 1988, with respect to advertising used on or after such date.

(d) TRANSITION FOR CURRENT POLICIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the period beginning on January 1, 1988, and ending on December 31, 1988 (or, if later, the date described in paragraph (2)(B) in the case of a medicare supplemental policy offered in a State identified under paragraph (2)(A)), no penalty may be imposed under subparagraph (A) of section 1882(d)(3) of the Social Security Act with respect to a medicare supplemental policy of an individual which—

(A) was sold with respect to the individual before the date of the enactment of this Act, and

(B) would not substantially duplicate health benefits to which an individual is otherwise entitled under title XVIII of such Act but for the amendments made by this Act.

(2) ADDITIONAL PERIOD ALLOWED TO PERMIT STATE LEGISLATION TO BE ENACTED.—

(A) IDENTIFICATION OF CERTAIN STATES IN WHICH ADDITIONAL PERIOD REQUIRED.—The

Secretary of Health and Human Services shall identify those States—

(i) which require State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to be changed to avoid a penalty under section 1882(d)(3)(A) of the Social Security Act, but

(ii) the legislature of which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered.

(B) ADDITIONAL PERIOD DATE.—In the case of a State identified under subparagraph (A), the date established under this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in subparagraph (A)(i) may be considered.

SEC. 210. EXTENSION OF SOCIAL HMO DEMONSTRATION PROJECT.

(a) THROUGH SEPTEMBER 30, 1992.—The Secretary of Health and Human Services shall extend without interruption, through September 30, 1992, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project de-

scribed in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by subsection (b)).

(b) EXTENSION OF RISK.—Section 2355(b)(5) of the Deficit Reduction Act of 1984 is amended by inserting "and in succeeding years" after "third year".

(c) INTERIM REPORT.—Section 2355(d)(2) of the Deficit Reduction Act of 1984 is amended by striking "final" and inserting "interim".

(d) FINAL REPORT.—The Secretary shall submit a final report to the Congress on the project referred to in subsection (a) not later than March 31, 1993.

SEC. 211. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1988, 1989, 1990, 1991, and 1992, to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

SEC. 212. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or

social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

SEC. 301. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR INDIGENT MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) SETTING INCOME STANDARD AT 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended by striking "may not exceed a percentage (not more than 100 percent) of the nonfarm" and inserting "shall be 100 percent of the".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII (including under part B and, if applicable, under section 1818)"; and

(2) by amending subparagraphs (B) and (C) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Deductibles established under title XVIII (including those described in section 1813 and 1833(b))."

(e) CONFORMING AMENDMENTS.—(1) Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended by adding after and below subclause (III) the following:

"and, to the extent required under subsection (m)(3), some or all of the individuals described in subsection (l)(1);".

(2) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1987" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures.'.".

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by sec-

tion 202(h)(3)(B), is amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for 100 percent any lesser percentage.".

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsection (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with July 1988, and

(B) items and services furnished on and after July 1, 1988.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds)

in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act.

SEC. 302. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Title XIX is amended—

(1) by redesignating section 1921 as section 1922, and

(2) by inserting after section 1920 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1921. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (g)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) ELECTION TO USE OTHER RULES.—An institutionalized spouse may elect not to have this section (other than subsection (c)) apply but to have the spouse's resources and income determined under the law, practice, or policy of the plan (whether approved or not) in effect on March 1, 1987, except to the extent inconsistent with subsection (c).

"(5) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted

under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of the individuals named in equal proportional shares.

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) unless the trust otherwise specifically provides—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of such individuals in equal proportional shares.

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superceded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse) a spousal share which is equal to ½ of the value of all the resources held by either the institutionalized spouse, community spouse, or both.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (e)(2)(A) (as of the time of application for benefits) or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

"(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(4) RESOURCES DEFINED.—In this section, the term 'resources' does not include resources excluded under subsection (a) or (d) of section 1613 and does not include resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(c) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the institutionalized spouse and which is not less than $25 per month.

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (6)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in paragraph (4), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allow-

ance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (5)); plus

"(iii) ½ of the amount by which the income available to the institutionalized spouse exceeds the sum of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsection (f)).

"(4) NOTICE AND FAIR HEARING.—

"(A) NOTICE.—Upon—

"(i) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(ii) a request by an institutionalized spouse (or community spouse or representative on the spouse's behalf),

each State shall notify the spouse of the amount of the community spouse monthly income allowance (described in paragraph (1)(B)), of the amount of any family allowances (described in paragraph (1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (e), and of the spouse's right to a fair hearing under subparagraph (B) respecting the determination of the community spouse monthly income allowance.

"(B) FAIR HEARING.—If an institutionalized spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established under paragraph (3)) is not

adequate to support the community spouse without financial duress, or

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under paragraph (2)(B)),

the institutionalized spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in paragraph (2)(A), an amount adequate to support the community spouse without financial duress.

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for mortgage payment (including principal, interest, taxes, and insurance and, in the case of a condominium or cooperative, required maintenance charge) or rent, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the

institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greater of—

"(i) $12,000 (subject to adjustment under subsection (f)), or

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i), exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(f) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1988, the dollar amounts

specified in subsections (d)(3)(B) and (e)(2)(A)(i) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1987 and the September before the calendar year involved.

"(g) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan

must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the application, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1921(g)(2);

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; and

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who—

"(A) is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution; and

"(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) CONFORMING AMENDMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of paragraph (46);

(3) by striking out the period at the end of the paragraph (47) inserted by section 9407(a) of the Omnibus Budget Reconciliation Act of 1986 and inserting a semicolon;

(4) in the paragraph (47) added by section 11005(b) of the Anti-Drug Abuse Act of 1986, by redesignating such paragraph as paragraph (48), by transferring and inserting such paragraph immediately after paragraph (47), and by striking the period and inserting "; and";

(5) by inserting after paragraph (48) the following new paragraph:

"(49)(A) meet the requirements of section 1921 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(6) by adding at the end the following new sentence: "For purposes of paragraph (10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(d) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraphs (2) and (3)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) The amendments made by subparagraphs (A) and (F) of subsection (c)(1) shall apply to medical assistance furnished on or after October 1, 1982.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

SEC. 401. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission").

SEC. 402. DUTIES.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

SEC. 403. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(1) The President shall appoint 3 members.

(2) The President Pro Tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members of the Senate, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same political party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 405(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

SEC. 404. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

SEC. 405. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Com-

mission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 406. REPORT.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 407. TERMINATION.

The Commission shall terminate 30 days after the date of submission of the report required in section 406(b).

SEC. 408. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

Passed the House of Representatives July 22, 1987.

Attest: DONNALD K. ANDERSON,

Clerk.

Calendar No. 258

100TH CONGRESS
1ST SESSION

H. R. 2470

AN ACT

To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes.

JULY 24 (legislative day, JUNE 23), 1987

Received; read twice and ordered to be placed on the calendar